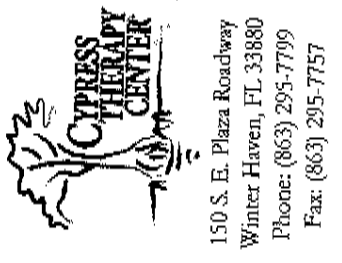


Patient Name: _____ Patient Phone: _____
 Diagnosis: _____
 Physician (print): _____ Date of Onset: _____
 Special Instructions/Precautions: _____
 PT _____ OT _____ Frequency and Durations: _____ x per week for: _____ weeks.
 Other: _____



EVALUATE AND TREAT

- | | | |
|--|--|---|
| <input type="checkbox"/> Pulmonary Rehab | <input type="checkbox"/> ROM Restrictions | <input type="checkbox"/> Respiratory Therapy |
| <input type="checkbox"/> Cardiac Rehab | <input type="checkbox"/> Spine Management | <input type="checkbox"/> Education/Breathing Retraining |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Cervical | <input type="checkbox"/> Strength Endurance Training |
| Manual Therapy | <input type="checkbox"/> Lumbar | <input type="checkbox"/> Maintenance Program |
| <input type="checkbox"/> Neuro Muscular Re-education | <input type="checkbox"/> Vestibular Rehabilitation | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Manual Traction | <input type="checkbox"/> Social Services | _____ |
| <input type="checkbox"/> Joint Mobilization | <i>(This patient needs social services)</i> | _____ |
| <input type="checkbox"/> Soft Tissue Manipulation | <input type="checkbox"/> Speech Language Pathology | _____ |
| <input type="checkbox"/> Gait Training | _____ | _____ |
| <input type="checkbox"/> Balance Training | _____ | _____ |

Physician Signature: _____ Date: _____
My signature authorizes this treatment to be medically necessary.

PLEASE FAX SCRIPTS TO OUR OFFICE AT 863-295-7757

*Thank you for your referral.
We will contact you upon receipt of this information.*

Physician's Signature: _____
Date: _____ / _____ / _____

Special Instructions:

- Type of Study Requested (CPT-4)**
- 95810 Baseline Study w/CPAP Titration if qualifies
 - 95811 CPAP Titration Study
 - 95811 Split Night Study
 - 95811 Re-Titration CPAP study
 - (Last Titration Study performed _____)
- Reason for Testing (ICD-9)**
- 780.53 Hypersomnia with Sleep Apnea
 - 780.54 Other Hypersomnia
 - 780.57 Other & Unspecified Sleep Apnea
 - 780.50 Sleep Disturbance, Unspecified
 - Other _____

Other
Patient's Chief Complaint: Obesity Loud Snoring Witnessed Apnea Excessive Daytime Sleepiness

Ins. Phone No.: _____ Auth No.: _____ No. of visits _____ Exp. Date _____ / _____ / _____
 Id No.: _____ Group No.: _____
 Insurance: _____ HMO PPO Other _____
 Daytime Phone: _____ Evening Phone: _____ Cell Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Patient Name: _____ D.O.B. _____ / _____ / _____

PHYSICIAN'S RX ORDER FOR SLEEP STUDY

Contact Person: _____ Phone Number: _____

Please send H&P or current office notes to
warrant sleep studies when available.

**PLEASE FAX TO: (863) 295-7757
OR CALL: (863) 295-7799**

150 S.E. Plaza Roadway
Winter Haven, Florida 33880

